Medicare Learning Network
MLN Matters
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - **Test Your Medicare Claims Now! After you have submitted claims containing both National Provider Identifiers (NPIs) and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with only the NPI in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch. (Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)**

MLN Matters Number: MM5713 Revised
Related Change Request (CR) #: 5713
Related CR Release Date: September 21, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1338CP
Implementation Date: January 7, 2008

Medicare Payment for Pre-administration-Related Services Associated with Intravenous Immune Globulin (IVIG) Administration—Payment Extended through CY 2008

Note: This article was revised on February 19, 2008, to add a reference to MM5741 to the Additional Information Section at the end of this article. All other information remains unchanged.

Provider Types Affected

Physicians or hospital outpatient facilities billing Medicare contractors (carriers, fiscal intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services related to the preadministration of Intravenous Immune Globulin (IVIG) for Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

In 2006 and 2007, Medicare made a separate payment to physicians and hospital outpatient departments for pre-administration-related services associated with administration of IVIG, Healthcare Common Procedure Coding System (HCPCS) code G0332.

CAUTION – What You Need to Know

CR5713, from which this article was taken, states that the Centers for Medicare & Medicaid Services (CMS) is extending the temporary IVIG pre-administration-related services payment to hospital outpatient departments and physicians that administer IVIG through calendar year (CY) 2008. This IVIG pre-administration service can only be billed by the physician or outpatient hospital providing the IVIG infusion once per patient per day of IVIG administration. For services on or after January 1, 2008, the service must be billed on the same claim form as the IVIG product (J1566, J1568, J1569, J1561 and/or J1572) and have the same date of service as the IVIG product and a drug administration service.

GO – What You Need to Do

Make certain that your billing staff is aware of these billing requirements.

Background

Under Section 1861(s)(1) and 1861(s)(2), Medicare Part B covers IVIG administered by physicians in physician offices and by hospital outpatient departments. More specifically, when you administer IVIG to a Medicare beneficiary in the physician office or hospital outpatient department, Medicare makes separate payments to the physician or hospital for both the IVIG product itself and for its administration via intravenous infusion.

This payment is for the additional pre-administration-related services required to locate and acquire adequate IVIG product during this current period where there may be potential market issues.

As a reminder, here are some important details that you should know:

- The policy and billing requirements concerning the IVIG pre-administration-related services payment are the same in 2008 as they were in 2007 and 2006.
- This IVIG pre-administration service payment is in addition to Medicare's payments to the physician or hospital for the IVIG product itself and for its administration by intravenous infusion.
- Medicare Carriers, FIs, or A/B MACs will pay for these services, that are provided in a physician office, under the physician fee schedule; and FIs or A/B MACs will pay for them under the outpatient prospective payment system (OPPS), for hospitals subject to OPPS (bill types: 12x, 13x) or under current payment methodologies for all non-OPPS hospitals (bill types: 12x, 13x, 85x).

- You need to use HCPCS code G0332, Pre-administration-Related Services for IVIG, to bill for this service.
- You can bill for only one IVIG pre-administration per patient per day of IVIG administration.
- For services on or after January 1, 2008, the service must be billed on the same claim form as the IVIG product (HCPCS codes J1566, J1568, J1569, J1561, and/or J1572) and have the same date of service as the IVIG product and a drug administration service. Physicians' claims will be rejected as unprocessable and hospital claims will be returned by your FI, carrier, or A/B MAC if one of the IVIG product HCPCS codes is not included with G0332 for that date of service. In doing so, the contractor will use one or both of the following codes:
  - M67-"Missing other procedure codes;" and/or
  - 16-"Claim/service lacks information which is needed for adjudication."
- Physicians' claims will be rejected as unprocessable and hospital claims will be returned for pre-administration-related services by your FI, carrier, or A/B MAC if more than 1 unit of service of G0332 is indicated on the same claim for the same date of service. They will use the appropriate reason/remark code such as:
  - M80-"Not covered when performed during the same session/date as a previously processed service for the patient;" and/or
  - B5-"Payment adjusted because coverage/program guidelines were not met or were exceeded."

Note: The definition for J1566 is changed effective January 1, 2008. The new definition is "Injection, immune globulin, intravenous, lyophilized (e.g., powder), NOS, 500MG."

Additional Information

For complete details regarding this issue, please see the official instruction (CR5713) issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1338CP.pdf* on the CMS website.

If you have questions, please contact your Medicare FI, carrier or A/B MAC at their toll-free number which may be found at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

You may want to view CR 5635, which implemented HCPCS Coding Changes for Immune Globulin, effective for services on or after July 1, 2007. For the article related to this CR, please visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5635.pdf* on the CMS site.

You may also want to view related article MM5741 ("Correction to Revised HCPCS Codes Relating to Immune Globulin (CR 5635)"), which is directed toward for DME MACs only may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5741.pdf* on the CMS website.

News Flash - It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because flu viruses change each year. Please encourage your Medicare patients who haven't already done so to get their annual flu shot. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu! Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition MLN Matters article SE0748 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf* on the CMS website."